H. Review of Prior Authorization System Updates

A system update is any alteration of an existing prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires, in order to ensure that services are not interrupted (405 IAC 5-3-1).

- Requests for system updates may be received in writing, by telephone, or via 278 electronic transaction from the requesting provider. Each request must contain information sufficient to support the requested change, and that information must be entered into the "Internal Text" screen as verification of the change. Providers must be instructed to clearly indicate the assigned PA number when submitting the requested documentation. This will alert the PA support specialist that the request need not be assigned a new number.

- System updates may include, but not be limited to, the following.

  - Extension of dates, limited to no more than six months beyond the original ending date of the existing PA.
  - Changed or incorrect procedure code(s), dates of service, decision code, or Recipient Identification (RID) number.
  - Administrative Review or Administrative Hearing decisions.
  - Change in the number of units based on a change in the condition or needs of the member.

  Following are examples of possible system update scenarios.

  - An IHCP member is receiving 10 hours of home health care five days a week while the primary caregiver works outside the home. The primary caregiver has emergency surgery and is unable to care for the member. The provider requests increased home health hours for 4 to 6 weeks until the primary caregiver can resume these responsibilities.

- A member has round trip transportation approved weekly to see the physician for treatment of a tenuous medical condition. The condition worsens, and the physician needs to see him or her twice weekly for three weeks, or until the condition stabilizes. The provider requests three additional round trips added to the PA.
- A member is approved for outpatient psychotherapy every two weeks. The patient's condition worsens, and the therapist feels it is necessary to see him or her twice weekly for two weeks or until the crisis subsides. The provider requests six additional units of outpatient psychotherapy added to the PA.

1. The following procedures should be followed by the PA support specialists for processing the request.

   a. System update requests are date stamped, sorted by type of service, and placed in the front of the folder for the same assignment group.

   b. The PA number the system update is referencing is retrieved in Indiana*AIM*. Click on System Update and enter the date the system update was received.

   c. These are placed directly on the shelves and a decision regarding the update is made and entered by the PA reviewer. A click on "system update" will cause the generation of a new decision letter once the PA is updated.

2. The following procedures should be followed by the PA reviewers for processing the request. Home health requests require specific suspension rule policy and the processing of these types of requests are outlined in item 3.

   a. Review the request for sufficient information to support the requested change.

   b. Determine the appropriate original PA (from the System Update Request Form) and select.

   c. Review the request following the PA review process and utilizing the appropriate criteria.

   d. Select "System Update" and enter appropriate date in "Update Reviewed."

e. If unable to approve or modify (partially approve) due to a lack of medical necessity, the system update is referred to the PA Supervisory Staff and PA Director for review. If the request cannot be approved, refer the case to a physician consultant for review.

f. Select "Line Item" and make desired changes in codes, units, dates, or decision fields.

e. Select "External Text", then "External Text Maintenance" and "New." (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for "Internal Text."

h. Proofread any text that will appear on the Decision Letter.

i. Be sure to select the "Batch Print" option before exiting the PA to ensure the system update decision will be batch printed and mailed to the requesting provider and the member.

3. The following procedures should be followed by the PA reviewer for processing home health requests. See **Figure III-15**.

a. Review the request for sufficient information to support the requested change.
b. Determine the appropriate original PA (from the System Update Request Form) and select.
c. Review the request following the PA review process and utilizing the appropriate criteria.
d. Select "System Update" and enter appropriate date in "Update Reviewed."

- ♦ If unable to approve or modify a home health request based on lack of documentation received through a system update within the 30-day suspension limit, suspend for an additional 30-days to allow for the documentation to arrive.

- ♦ The external text must include a detailed description of the required documentation necessary to make the decision.

e. If unable to approve or modify (partially approve) due to a lack of medical necessity, the system update is referred to the PA Supervisory Staff and PA Director for review. If the request cannot be approved, refer the case to a physician consultant for review.

f. Select "Line Item" and make desired changes in codes, units, dates, or decision fields.

g. Select "External Text", then "External Text Maintenance" and "New." (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for "Internal Text."

h. Proofread any text that will appear on the Decision Letter.

i. Be sure to select the "Batch Print" option before exiting the PA to ensure the system update decision will be batch printed and mailed to the requesting provider and the member.

Any reduction or denial of ongoing services by the PA reviewer requires that the member receive notification of the reduction or denial at least 30 calendar days from the date of the decision.

If the member has not been given proper notice of the proposed reduction, and files an appeal within 10 days of the mailing of the notice, services must be restored to their previous level, pending the results of the appeal. Refer to the Section IV concerning Hearings and Appeals. Notice is not required if the request is a first request for those services, or the previous PA expired prior to the receipt of the current prior authorization request.

Refer to **Table III-12**, for the step-by-step procedure for Modification of an Approved Prior Authorization (System Update) and **Exhibit VI-15,** for a copy of the Prior Authorization System Update Request Form.

FIGURE III-15
PRIOR AUTHORIZATION REVIEW PROCESS
HOME HEALTH PA FOR SUSPENSIONS

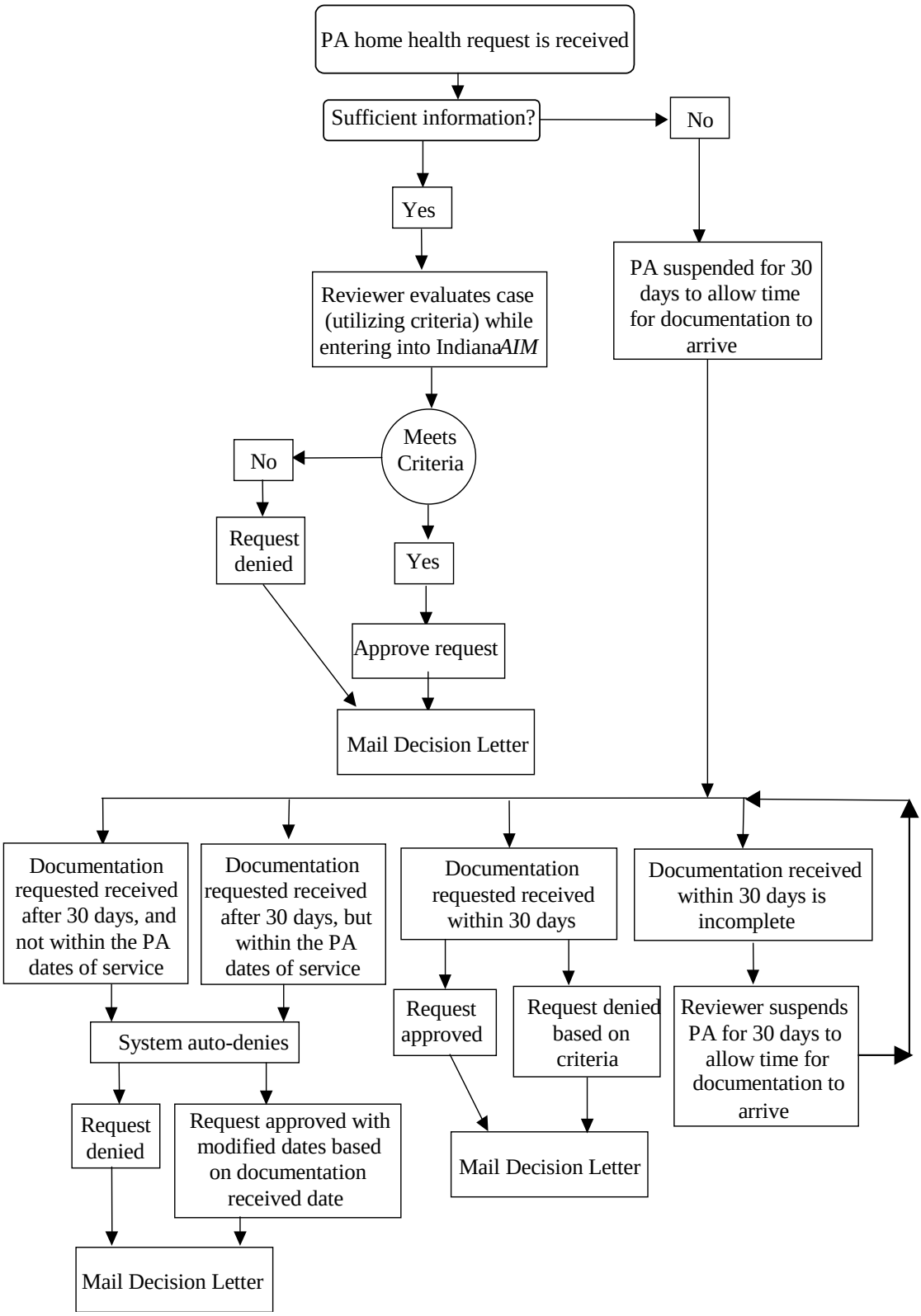


TABLE III-12

PROCEDURE/PROCESS: MODIFICATION OF AN APPROVED PRIOR AUTHORIZATION (SYSTEM UPDATE)

No.	Description of Activity	Responsible Party
1.	Request to modify an approved authorization can be received in writing, by telephone, or via 278 electronic transaction from the requesting provider.	Provider
2.	Requests that are received by mail are date stamped and sorted by type of service.	PA Support Specialist
3.	Requests are placed in the front of the same assignment group folders.	PA Support Specialist
4.	The PA number the system update is referencing is retrieved in Indiana*AIM*. Click on "System Update" and enter the date the request was received.	PA Support Specialist
5.	The folders are placed on the appropriate shelf in the reviewer staging area to be retrieved for review.	PA Support Specialist
6.	Determine the appropriate original PA from the System Update Request Form and select the request to be modified.	PA Reviewer
7.	Review the request for sufficient information to support the requested change.	PA Reviewer
8.	Review the request following the PA review process and utilizing the appropriate criteria.	PA Reviewer
9.	Select "System Update" and enter appropriate date in the "Update Reviewed" field.	PA Reviewer
10.	If unable to approve or modify the request based on medical necessity, refer the case to a PA supervisor for a denial review through the appropriate chain of command.	PA Reviewer
11.	If able to approve or modify the request, select the appropriate line item and make the desired changes in codes, units, dates, or decision fields.	PA Reviewer
12.	Select "External Text", then "External Text Maintenance" and "New." (A clean screen will appear.) Enter the information provided supporting the system update request. Repeat this procedure for "Internal Text."	PA Reviewer
13.	Select "Batch Print" to generate a new decision letter to the provider and member.	PA Reviewer
14.	Any reduction or denial of ongoing services requires the member receive notification of the reduction or denial at least 10 business days prior to the implementation of the denial or modification. Therefore the mailing of the decision must occur 13 days prior to the proposed reduction.	PA Reviewer
15.	Return the written System Update Request Forms to the top shelf of the metal file cart in the center aisle of the PA department for inventory and filing.	PA Reviewer
16.	Services must be restored to their original level pending the results of an appeal, if the member is not given proper notice of the proposed reduction.	PA Hearings and Appeal Specialist

I. Internal Grievance Procedure

Definition

When the requesting provider/agency believes the reviewer rendering the prior authorization decision has made an error AND the member will suffer harm if time lapses in order to follow the Administrative Review/Appeals process, he or she may utilize the internal grievance process. When providers call with individual problems, they will be informed of this internal grievance process and the procedure will be explained at that time.

The internal grievance process is available on a very limited basis whether the request was submitted in writing, by telephone or faxed. The following sequence must be followed for reconsideration of a prior authorization request.

Procedures

1. The requesting provider/agency must contact the reviewer who originally reviewed the request and provide any additional information omitted during the initial review. A provider choosing to initiate the internal grievance procedure can request their call be transferred to this reviewer. If it is agreed that the additional information warrants a change of the original decision, a system update may be completed.

   If the reviewer does not believe the additional information is sufficient to change the decision nor does the member's health and safety seem in jeopardy nor does the situation appear to necessitate immediate review, the provider will be requested to submit a written request for Administrative Review. The prior authorization decision remains unchanged (The reviewer may wish to review the case with the PA supervisor.)

2. If the requesting provider/agency still believes the decision may jeopardize the health and safety of the member, he or she may request to speak with the reviewer's supervisor. Upon hearing the facts of the case, the supervisor must determine if the situation warrants immediate review or a change of the prior authorization decision (The supervisor may wish to review the case with the PA director.)

   If the supervisor does not believe the additional information is sufficient to change the decision, nor does the member's health and safety seem in jeopardy or the situation appear to necessitate immediate review, the provider is requested to submit a request for

Administrative Review. The prior authorization decision remains unchanged.

3. If the requesting provider/agency is still dissatisfied, he or she may request to speak with the prior authorization director. The director renders the final decision. All the available information, including laws, rules, criteria and other resources utilized to make determinations, will be considered. Clinical validation will be sought as needed from other medical professionals within or outside the prior authorization department. Interpretation of the IAC or a final decision may be requested from the appropriate person(s) in the Office of Medicaid Policy and Planning.

   Ample opportunity has been afforded, to this point, to safeguard possible errors that may jeopardize the well-being of the member.

   At NO time will this process be circumvented by any party. Consistency creates protection from liability and the assurance that all applicable rules and criteria are followed accurately.

J. Referral to Consultants

Requests for services or supplies which PA reviewers are unable to approve or modify because they are not within the established guidelines by the IAC, established criteria, IHCP bulletins, or other directives of the Office of Medicaid Policy and Planning, will be referred by the PA reviewer to the PA supervisory staff.

The PA supervisory staff will evaluate the case to ensure that all available documentation and criteria have been assessed. If the request cannot be approved or modified, it will be referred to the Medical Director or a consultant by the PA director for further review according to the following procedure.

1. The PA reviewer will determine the appropriate medical specialist such as neurologist, psychiatrist, dentist, etc.

    a. Cases, in which the reason for denial is noncompliance with the IAC or other rules, will not be referred to a physician consultant. The PA supervisory staff will address these cases. Only denials related to medical necessity may be referred to a consultant.

    b. Peer reviewers will be used to render a medical judgment on the partial or full denial of services or payment. For instance, a physical therapist may be consulted in a case in which physical therapy services are requested; or, a plastic surgeon may be consulted in cases in which plastic or reconstructive surgery is requested. If a consultant is not available, the PA director will refer the case to the Medical Director for assistance in securing the services of a peer reviewer.

2. The support specialist will contact the selected consultant to ensure availability and willingness to evaluate the case.

3. If the supply or service is elective in nature, the PA support specialist will mail the case documentation to the consultant. The consultant must complete and return the decision within 10 days from the original request received date. If the supply or service is considered to be an emergency, the case will be described, in detail, via telephone conference with the consultant, or the Medical Director will be consulted, if necessary, to expedite the process.

4. The consultant will make the decision regarding medical necessity based upon current standards of practice and professional judgment, rather than upon the criteria guidelines, which are utilized by the PA reviewers and PA specialists. (Refer to **Exhibit III-2, Medical Rationale** and **Exhibit III-3, Consultants Avoiding Common Review Errors**.) However, these professionals are still constrained by State of Indiana rules and regulations regarding coverage issues.

5. The consultant will record the decision, citing rationale, and return all case documentation to the HCE office if the process is completed by mail. If the process is performed by telephone, the PA specialists or PA supervisor will document the rationale cited by the consultant.

6. The support specialist will be responsible for tracking individual requests forwarded to a consultant. The request timelines are monitored by a tickler system that will prompt the support specialist to contact the consultant for a decision status. Requests forwarded to a consultant must be returned with a decision that will allow notification to the provider and member within a ten day timeframe. For example, if a request is forwarded to a consultant on day three and has not been returned to the support specialist by day seven, the support specialist will contact that consultant. If it is determined that the consultant will be unable to render a decision by day 10, a second consultant will be contacted to review the request. The request will be retickled for compliance with the 10 day timeframe. A consultant decision may be received by telephone or fax if unable to mail the decision within the 10 day timeframe.

7. If the original denial decision has been changed by the consultant, the PA supervisor will enter the new decision into Indiana*AIM* which will generate a new decision letter which will be mailed by EDS. If the original denial decision is upheld by the consultant, the signed returned denial letter will be mailed individually by HCE to the provider and member within 24 hours.

K. Review of Psychiatric Admissions with the 1261A-Certification of Need

Medicaid reimbursement is available for inpatient psychiatric services only when the member's need for admission has been authorized. According to the Indiana Administrative Code, the Certification of Need must be completed as follows (405 IAC 5-20-5).

- By the attending physician or staff physician for an IHCP member between 22 and 65 years of age in a psychiatric hospital of 16 beds or less, and for an IHCP member 65 years-of-age and over.
- In accordance with 42 CFR 441.152(a) and 42 CFR 441.153 for an individual 21 years of age and under.
- By telephone, fax, or 278 electronic transaction precertification prior to admission for an individual who is a member of IHCP when admitted to the facility as a **non-emergency** admission, to be followed by a written Certification of Need within 10 business days of admission.
- By telephone fax, or 278 electronic transaction precertification within 48 hours of **emergency** admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written Certification of Need within 14 business days of admission. If the provider fails to call within 48 hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, IHCP reimbursement will be denied for the period from admission to the actual date of notification.
- In writing, or 278 electronic transaction within 10 business days after receiving notification of an eligibility determination for an individual applying for IHCP while in the facility and covering the entire period for which IHCP reimbursement is being sought.
- In writing, or 278 electronic transaction at least every 60 days after admission, or as requested by the OMPP or its designee, to recertify that the patient continues to require inpatient psychiatric hospital services.

IHCP reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary. Telephone prior authorizations of medical necessity will provide a basis for IHCP reimbursement only if adequately supported by the written Certification of Need submitted in accordance with 405 IAC 5-20-5. If the required written documentation is not submitted within the specified time frame, IHCP reimbursement will be denied (405 IAC 5-20-7).

The Certification of Need (1261A) is a four page form in triplicate that must be submitted by the provider within 10 days for non-emergency admissions, and within 14 days following emergency admissions for psychiatric or substance abuse treatment.

All 1261As are to be reviewed for timeliness and medical necessity, entered into Indiana*AIM*, and returned to the provider within 10 working days of receipt.

Review Process

- 1261As are received by the PA support specialist from the mail room staff.
- Because of the strict time limit mandated in the Indiana Administrative Code, it is imperative for each 1261A to be clearly stamped with the date the form is received by HCE.
- If the stamped date is beyond the acceptable time limit, all of the days of that hospitalization will be denied. Therefore, it is very important to be able to determine the exact date the forms were received.
- After the forms are date stamped, they are placed in a designated area in date received order.
- The PA reviewers will retrieve the 1261As and review each document for timely submission and for medical necessity utilizing the appropriate criteria.
- All 1261As received with retroactive requests for review must be kept with the retroactive request and attachments. By doing this, the reviewer can process not only the request, but also the 1261A simultaneously.

- After the review process is completed, the top copy (white copy) of the 1261A must be detached from each of its pages, stapled together, and returned to the provider for attachment to the medical record. If the provider submitted a single page form, the 1261A must be copied and the signed original returned to the provider. The copy is maintained in HCE records. The provider must keep this document as a part of the medical record for postpayment review. The PA support specialist will complete this function.

The following is a step-by-step procedure for processing the 1261A.

1. Pull up the previously assigned PA.

2. Determine if the 1261A was submitted timely.

   - Add 14 business days from the date of admission for emergency admissions.

   - Add 10 business days to the date of admission for non-emergency admissions.

   If the submission is untimely it must be denied.

3. If the PA number on the 1261A is incorrect, pull up PA history by using the Recipient Identification (RID) number. Locate the correct PA, by dates of service, and pull it up. If both the PA and the RID numbers are incorrect, return the 1261A to the provider for correction. If the request is returned from the provider after an additional 14 business days (from the date returned to the provider), the request will be determined "untimely" and the "pending" days will be "denied." It is the responsibility of the provider to submit correctly completed documentation in a timely manner.

4. Review the information contained in the 1261A.

   - Does the documentation support the need for an emergency admission?
   - Does the plan of treatment seem appropriate for this type of case?
   - Is the discharge plan realistic for this member?
   - Has the physician signed the last page?

5. Is the date of the physician's signature fewer than 14 days from the date of admission? If the signed date indicates the document was signed within the 14 business day time limit, review for medical necessity of the admission. If the document was signed after 14 business days, the request for approval of the days must be denied.
6. Based on the 1261A and the faxed or telephoned request for PA, the reviewer will make a decision to approve or modify (partially approve) or refer to a higher level of review.
7. Pull up the line item.
    - If approved or modified (partially approved), change the "pending" days to "approved".
    - If referred, leave the decision as "pending" until a decision has been made to approve, modify, or deny. Refer the case to a PA supervisor or the PA Director.
8. After the decision has been made, change the "pending" days to the correct code.
9. Click on the "Psychiatric" box on the left of the PA screen.
    - Enter the date the 1261A was received.
    - Enter the date the 1261A was reviewed and entered into the system.
10. Use the pull-down box to find and select the most appropriate diagnosis.
11. If the information supports the denial of the request, use both the internal and external text options to document the rationale for the denial.
12. Proofread the external text. This text is sent to members and providers; it should be clear, concise, accurate, and free of any misspellings or typographical errors.
13. Click on "batch print" to generate copies for automated mailing to the provider and the member the following day.

Refer to **Table III-13,** for the step-by-step procedure for Modification of a Pending Prior Authorization, **Figure III-16,** (PA Psychiatric Diagnosis Selection Window), **Figure III-17,** (PA Psychiatric 1261A Window), and **Exhibit VI-6,** (OMPP Form 1261A) for detailed explanation of review of 1261As.

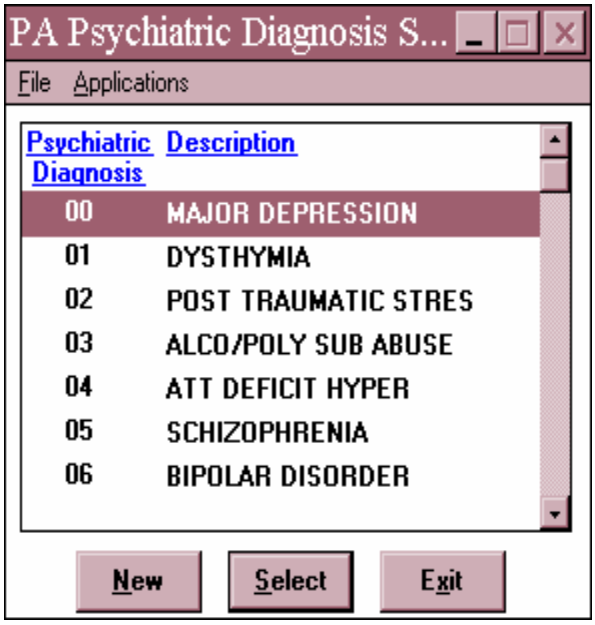
TABLE III-13

PROCEDURE/PROCESS: MODIFICATION OF A PENDING PRIOR AUTHORIZATION

No.	Description of Activity	Responsible Party
1.	Provider submits for a phone request, which meets the criteria for a phone PA pending a decision based on paper documentation received via mail.	Provider PA Reviewer
2.	The Certificate of Need (1261A) is received via mail and stamped with the date received at HCE.	PA Support Specialist
3.	The forms are placed on the shelves for review.	PA Support Specialist
4.	Retrieve the PA history in Indiana*AIM* by using either the RID number, member name, or the PA number. If member cannot be identified, the 1261A is returned to the provider and must be received back within 14 business days of the return date or the pended approval will be denied.	PA Reviewer
5.	The previously assigned PA is pulled up in Indiana*AIM* and a determination will be made if the 1261A is submitted timely. If the submission is untimely, the request will be denied.	PA Reviewer
6.	Verify the admission dates on the PA and the 1261A agree. If they do not, the PA may not have been requested until after the 48 hour time limit during which authorization may be requested for an emergency admission.	PA Reviewer
7.	Review the information contained in the 1261A for medical necessity.	PA Reviewer
8.	Review the stamped received date and the date of admission. If the date span is greater than 14 business days, the request for approval of the days must be denied.	PA Reviewer
9.	If the 1261A was received within the 14-business day time limit, review for medical necessity of the admission.	PA Reviewer
10.	Based on the PA and the 1261A, make a decision to modify the case.	PA Reviewer
11.	Retrieve the line item in Indiana*AIM* and change the pending days to approved.	PA Reviewer
12.	Click on the “Psychiatric” box on the left of the PA screen and enter the date the 1261A was received, reviewed, and entered into the system.	PA Reviewer
13.	Enter the most appropriate diagnosis in the diagnosis field.	PA Reviewer
14.	Use both the internal and external text options to document the rationale for the modification to the original pending request.	PA Reviewer
15.	Initiate “batch print” to automatically generate a decision letter to the provider and member.	PA Reviewer
16.	After the review process is complete, the 1261A is broken down, or copied, and the original is returned to the provider for attachment to the medical record. **The support specialist MUST use extreme caution in the return of the 1261A. Due to the highly confidential nature of the information documented on the 1261A, the support specialist will check the address on the 1261A and compare to the address on the envelope at least twice. Also, to ensure the 1261A is returned to the correct person at the facility it shall be addressed directly to the representative who submitted the 1261A or to the attention of the Director of Utilization Review.**	PA Support Specialist

FIGURE III-16

WINDOW: PA PSYCHIATRIC DIAGNOSIS SELECTION

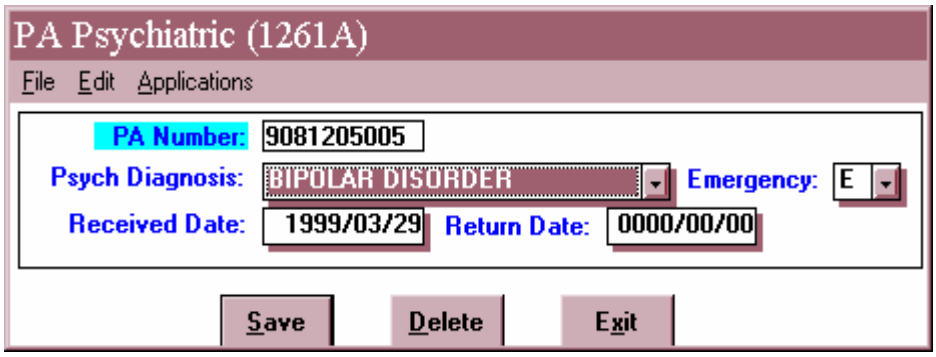


The PA Table Maintenance Menu is used to store psychiatric diagnosis. These are used for reporting purposes for the Psychiatric reports. Valid values include the following.

00	Major Depression/Depression NOS
01	Dysthymia
02	Post Traumatic Stress Disorder
03	Alcohol/Poly Substance Abuse/Dependency
04	Attention Deficit Hyperactivity Disorder
05	Schizophrenia
06	Bipolar Disorder
07	Oppositional-Defiant Disorder/Conduct Disorder
08	Adjustment Disorder
09	Other
10	Conversion/No Date

FIGURE III-17

WINDOW: PA PSYCHIATRIC (1261A)



Psych Diagnosis: The drop down list box that includes the valid values used for Psych reports. Select the appropriate value and then tab to the next field.

Emergency: The indicator with valid values of 'E' or 'N' used to indicate if this admission to a Psychiatric facility is an emergency or a non-emergency.

Received Date: The date in CCYYMMDD format that the PA staff received the 1261A form from the Provider.

Return Date: The date in CCYYMMDD format that the PA staff returned the 1261A form to the Provider.

L. Review of Hospice Services

Hospice is defined as a system of family-centered care designed to assist the terminally ill person to be comfortable and to maintain a satisfactory life-style through the phases of dying. Hospice care is multidisciplinary and includes the availability of professional health care on call, home visits, teaching and emotional support of the family, and physical care of the member. Hospice services include palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program member during the final stages of the member's terminal illness. In addition, hospice services include care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

The Indiana Administrative Code defines hospice as a person or health care provider who owns or operates a hospice program or facility, or both, that uses an interdisciplinary team directed by a licensed physician to provide a program of planned and continuous care for hospice program patients and their families. The hospice program is a specialized form of interdisciplinary health care that is designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease.

Hospice services became covered under the Indiana Health Coverage Programs on July 1, 1997. IHCP hospice rules can be found at 405 IAC 1-16, 405 IAC 5-2, and 405 IAC 5-34.

IHCP reimbursement is available for hospice services. Providers must meet certain conditions in order to receive reimbursement as hospice providers under the IHCP.

- A provider must submit a separate provider enrollment agreement (even if the provider currently participates in the IHCP as a provider of another service).
- A hospice provider must be certified as a hospice provider in the Medicare program.
- The provider must comply with all State and Federal requirements for IHCP providers.

- The hospice provider must designate an interdisciplinary group composed of individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include all of the following persons:

  - a medical director, who must be a doctor of medicine or osteopathy;
  - a registered nurse;
  - a social worker; and
  - a pastoral or other counselor.

- The interdisciplinary group is responsible for the following:

  - participation in the establishment of the plan of care;
  - provision or supervision of hospice care and services;
  - review and updating of the plan of care; and
  - establishment of policies governing the day-to-day provision of care and services.

IHCP reimbursement for hospice services is made at one of four all-inclusive per diem rates for each day in which an IHCP member is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories.

- Routine home care is when the member is at home, a private home or a nursing facility (NF), under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The hospice provider receives the hospice per diem pay only if the member is in a private home. If the patient is in a nursing facility, the hospice provider receives the hospice per diem plus 95% of the lowest nursing facility room and board per diem (the hospice provider pays the nursing facility).

  Effective October 1, 1998, reimbursement for the nursing facility room and board services shall be 95% of the single nursing facility case mix rate.

- Continuous home care in a private home or nursing facility is provided only during a period of crisis (a period in which a member requires continuous care, that is primarily nursing care, to achieve palliation and management of acute medical symptoms). Either a registered nurse or a licensed practical nurse must provide this care, and a nurse must provide care for over half the total period of care. A minimum of eight hours of care must be provided during a 24 hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. In a private home, the hospice provider receives the hospice per diem only. Effective October 1, 1998, reimbursement for NF room and board services shall be 95% of the single NF case mix rate.

- Inpatient respite care is paid for each day that the member is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the member only when necessary to relieve the family members or primary caregivers. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

- The general inpatient hospice rate is paid for each day the member is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The member must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the member's record must clearly explain the reason for admission and the member's condition during the stay in the facility at this level of care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the member receives general hospice inpatient care.

  The hospice provider is the professional manager of the member's care regardless of the physical setting or the level of care. If the inpatient facility is not also the hospice provider, then the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.

The usual home of the hospice member determines the location of care for that member. The private home location of care applies if the member usually lives in his or her private home. Nursing facility location of care applies if the member usually lives in a nursing facility. Members in freestanding hospice facilities are considered to be living "at home," unless the freestanding facility is authorized as a nursing facility.

1. Authorization of Hospice Services

Hospice services require hospice authorization. Hospice authorization is also required for any IHCP-covered service not related to the hospice member's terminal condition if hospice authorization is otherwise required. Hospice Authorization is not required for the following services when provided to hospice members.

- Pharmacy services for conditions not related to the member's terminal condition. Pharmacy services related to the member's terminal condition also do not require hospice authorization because they are included in the hospice per diem.
- Dental services do not require hospice authorization.
- Vision care services do not require hospice authorization for hospice members.

In order to obtain authorization for hospice services, the provider must submit all of the following with an Indiana Prior Review Authorization Request.

a. There must be a member election statement.

In order to receive hospice services, a member must elect hospice services by filing an election statement with the hospice provider.

Election of the hospice benefit requires the member to waive IHCP coverage for the following services:

- other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness;

- services provided by another provider which are equivalent to the care provided by the elected hospice provider; and

- hospice services other than those provided by the elected hospice provider or its contractors.

The effective date for the election must begin with the first day of hospice care or any other subsequent day of hospice care.

The provider must request Revenue Code 651 as the requested service code, and will bill with the appropriate revenue code reflecting the actual hospice service rendered.

The election form must be submitted to HCE, Prior Authorization department, when hospice services are initiated. It is not necessary to submit the election form for the second and subsequent benefit periods unless the member has revoked the election and wishes to re-elect hospice care.

In the event that a member, or the member's representative, wishes to revoke the election of hospice services, the following apply.

- The member must file a hospice revocation statement on a form approved by the State. The form includes a signed statement that the member revokes the election of IHCP hospice services for the remaining days in the benefit period.

- A member may elect to receive hospice care intermittently rather than consecutively over the benefit periods. The benefit approval period begins with an initial approval of 90 days, a second approval period of 90 days and then unlimited 60-day periods will restart where they were stopped, should the member choose intermittent services.

- If a member revokes hospice services during any benefit period, time remaining on that benefit period is forfeited. The IHCP hospice benefit mirrors the Medicare Hospice Program. If the member re-elects the IHCP benefit, then the member is re-enrolled into the subsequent hospice benefit period. For example, if a member revokes the first hospice benefit period, and then chooses to re-elect hospice care, the member would be enrolled into the second hospice benefit period. If a hospice provider discharges a hospice member and then re-enrolls the member, the re-enrollment begins with the next hospice benefit period.

A member, or the member's representative, may change hospice providers once during any benefit period. This change does not constitute a revocation of services.

b. The provider must submit the physician certification form.

In order for a member to receive IHCP covered hospice services, a physician must certify that the member's prognosis is for a life expectancy of six months or less if the terminal illness runs its course (the member is terminally ill and expected to die from that illness within six months).

- The Medicaid Physician Certification form must be signed by the Medical Director of the hospice program and the attending physician for the first hospice benefit period. For subsequent benefit periods, if the Medical Director signs the Medicaid Physician Certification form, then the signature of the attending physician is not required. If the Medical Director cannot sign the Medicaid Physician Certification form, then the signature of the physician member of the interdisciplinary team and the signature of the member's attending physician are required (except in cases where the member has no attending physician).

- The Medicaid Physician Certification form must be signed and dated.

- The Medicaid Physician Certification form must identify the diagnosis that prompted the member to elect hospice services and must include a statement that the prognosis is six months or less.

- The Medicaid Physician Certification form must be submitted within certain timeframes. For the first election period the Medicaid Physician Certification form must be submitted within 10 business days of the effective date of the member's election. For the second and subsequent periods the Medicaid Physician Certification forms, including updated care plans, etc., must be submitted within 10 business days of the beginning of the benefit period.

c. The provider must submit a plan of care. The Medicaid Hospice Plan of Care form must be submitted with the Medicaid Physician Certification form and the Medicaid Hospice Election form. In developing the plan of care, the provider must comply with the following procedures.

- One of the conferees must be a physician or a nurse, and all other team members must review the plan of care.

- All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

Hospice eligibility is available in the following benefit periods:

- one period of 90 days;
- a second period of 90 days; and
- an unlimited number of periods of 60 days.

Approval must be granted separately for each benefit period. If benefit periods beyond the first 90 days are necessary, then re-certification on the Medicaid Physician Certification form and an updated Medicaid Hospice Plan of Care form are required for hospice authorization of the second and subsequent benefit periods.

When approval for a benefit period has been granted, a hospice provider may manage a patient's care at the four levels of care, according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient's family or primary caregivers. Changes in levels of care do not require hospice authorization as long as these levels are rendered within a prior approved hospice benefit period.

A member, or representative of the member, who is not satisfied with his or her hospice provider may change hospice providers during any benefit period. This change does not constitute a revocation of service. To change a designated hospice provider, the member, or the member's representative, must file a Hospice Provider Change Request between Indiana Hospice Providers form. The hospice provider may fax this form to the HCE Prior Authorization unit so long as all hospice benefit period(s) preceding the date of the hospice revocations have been previously authorized.

If the hospice analyst discovers that there is a hospice authorization for the same dates of service in Indiana*AIM* which have been authorized for another hospice provider, the hospice analyst may not process the hospice authorization submitted by the new hospice provider until this discrepancy is resolved. The hospice analyst will resolve this issue as follows:

- For purposes of this explanation, the *original* hospice provider refers to the provider that first provided hospice services to the IHCP hospice member under the IHCP hospice benefit but who never formally notified the Prior Authorization Unit of any discharge/transfer to another provider. The *new* hospice member refers to the provider that recently assumed the management of the IHCP member's hospice care.

- The new hospice provider that submits the hospice authorization must coordinate with the original hospice provider that maintains the hospice authorization for dates of service that duplicates the new hospice provider's dates of service.

- Once the new hospice provider obtains the Hospice Provider Change Request between Indiana Hospice Providers form, the new hospice provider must resubmit the Hospice Provider Change Request between Indiana Hospice Providers form with the election packet. The hospice analyst will enter the day of the change in provider as the first day of that hospice benefit period.

2. Procedure for processing of initial hospice requests.

   a. The mailroom will forward the hospice requests to the Prior Authorization department.

   b. The PA support specialist(s) will sort the hospice requests, date stamp and place the forms in a hospice assignment group folder.

   c. The hospice requests will be forwarded to the hospice analyst.

   d. The hospice analyst will evaluate the packet to ensure that all forms are present, including the Medicaid Physician Certification form, member Medicaid Hospice Election form, and Medicaid Hospice Plan of Care form. If all forms have not been included, or are incomplete, the request will be suspended. The specialist will note the date the request was received by Health Care Excel and will modify as necessary for untimeliness. For each day the request is beyond the 10 business day filing limit, the start date will be modified one calendar day.

e. If the member is dually eligible, the hospice analyst will accept the Medicaid hospice authorization notice for dually-eligible Medicare/Medicaid nursing facility residents. The hospice analyst will validate member and provider information and follow Medicaid Hospice enrollment procedures. Dually eligible Medicare/IHCP members must elect, revoke, or change providers under both the Medicare and the IHCP programs at the same time. The hospice provider must notify both programs of any changes in the dually eligible Medicare/IHCP member's hospice care status.

f. The hospice analyst will evaluate each form for completeness. The hospice analyst will suspend the request if it is not complete. The analyst will communicate with the provider via the Prior Authorization decision letter what paperwork is needed.

g. The hospice analyst will evaluate the member Medicaid Hospice Election form to see if the hospice provider exists in the system as a hospice provider (type/specialty = 06/060).

h. The hospice analyst will verify that the member exists in the system. If the RID is not valid, look for the member by SSN or name to find the valid RID. If unable to determine a valid RID, the packet is returned to the provider with instructions to supply the correct RID number.

i. The hospice analyst will verify that the member's signature is present on the Medicaid Hospice Election form. If it is missing, the provider must resubmit the form with the signature included.

j. The hospice analyst will retroactively extend the member's hospice eligibility ten (10) business days or to the effective date on the election form. The hospice eligibility date may only be extended past ten (10) business days if the member's eligibility has been retro-authorized by the Division of Family and Children. (This retro-eligibility will be identified in the member database in Indiana*AIM.)*

k. If a nursing facility has been listed on the form, the hospice analyst will check to see if the correct nursing facility appears in the Level of Care (LOC) window. If the nursing home LOC segments are not present or are different from what was entered on the form, the hospice analyst will suspend the request and ask the provider to submit a system update request when the nursing facility has an approved 450B form for the dates of service in question.

l. If any of the forms require corrections, the hospice analyst will suspend the request and require the hospice provider to make corrections. The provider will have 30 days to send the correct information to HCE for processing.

m. For requests that do not require corrections, the hospice analyst will add the hospice LOC information for the member using the Member LOC window. If the member already has hospice LOC information loaded, and the stop reason for the last benefit period indicates the member revoked, or was discharged, then this is considered a "re-enrollment." For these cases, the hospice analyst will check which benefit period was activated previously, compare it to the new Medicaid Physician Certification form, determine the new LOC segment information, and enter it in the LOC window.

n. Enter the hospice analyst ID (this item must be alpha numeric).

o. Enter the hospice provider ID that appears on the Medicaid Hospice Election form. Enter the period that the hospice member is entering in the LOC field (51H, 52H, and 53H).

p. Enter the reason for starting a hospice period in the start reason field.

- 51H First 90 day benefit
- 52H Second 90 day benefit
- 53H Third and subsequent benefit periods

q. Enter the approved start date for the period being set up in the start date field (CCYYMMDD). Never enter a date before 7/1/97.

r. Enter the reason for stopping a hospice period in the stop reason field.

- 51H Member revocation
- 52H Hospice revocation
- 53H Transfer to another hospice provider

- 54H Death
- 55H Enrollment period limitations
  Dually-eligible Medicare and IHCP eligible members residing in a nursing facility will have matching Medicare/IHCP stop dates for the hospice benefit period.

s. Enter the appropriate stop date based on the segment being set up. The stop dates should be 90, 90, or 60 calendar days from the start date depending on the period (CCYYMMDD).

t. If the member is enrolled in an IHCP managed care delivery system, the hospice analyst will contact Americhoice, IHCP's managed care enrollment broker contractor, and request the member be disenrolled. (A copy of the Medicaid Hospice Election form is faxed to Americhoice to serve as documentation.) Americhoice will disenroll on the same day and return, by fax, a disenrollment notification so that hospice enrollment may proceed on the following disenrollment day. Files for previous managed care members are filed in "Hospice" files.

u. If the member is already enrolled in the 590 Program, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), Undocumented or Unqualified Aliens, Children's Special Health Care Services (CSHCS), a PA denial is issued for the member. The denial must indicate that the member must be IHCP only eligible or disenrolled to be eligible for hospice services. The reason for denial is documented on the hospice return letter. A denial notice must also be sent to the member.

v. If the member is already enrolled in a Home and Community Based Services (HCBS) waiver program, notify the State waiver unit (317-232-5110) of the changes that were requested and enter the hospice segment. The Waiver unit and OMPP Policy analyst are notified of the name and RID number of IHCP Waiver hospice member in the event access to service or billing issues arise. Waiver members do not have to disenroll from the waiver program before electing the IHCP hospice program.

w. If the member is already enrolled as a restricted card member, the analyst should proceed with the enrollment, copy the request and submit to the SUR restricted card supervisor who will disenroll the member from restricted card. This should occur the same day to ensure correct claims processing. The packet should include a highlighted end-date for restricted card status, which should be at least one business day prior to the hospice effective date. In other words, no overlap should occur, or a claim denial could occur.

x. If a member Indiana*AIM* eligibility window reflects a date of death, the hospice election is processed to reflect the date of death as the hospice stop date. If a Medicaid Hospice Discharge form was not received with the benefit request, a date of death discharge letter is sent to the hospice provider indicating the stop date is modified to reflect the date of death. The hospice provider is instructed to submit a discharge form to complete the member hospice file.

y. Send decision letter to the provider and member as an acknowledgment that the hospice period has been approved and entered.

z. File the request and retain for three years.

3. The following is the process for member re-election to the next benefit period.

a. If the enrollment request does not have a Medicaid Hospice Election form, it may be a "re-election" to the next benefit period, which means that the member is already enrolled. Check the Medicaid Physician Certification form for which benefit period is indicated.

b. Review the Medicaid Hospice Plan of Care and Medicaid Physician Certification forms.

c. If any of the forms require corrections, the request is suspended and the packet is returned to the hospice provider with a letter indicating the necessary corrections. The provider will have 30 days to send correct information to HCE for processing.

d. Enter the re-election update information using the LOC window to activate the next benefit period.

e. Enter the hospice analyst ID (this item must be alpha numeric).

f. Enter the hospice provider ID that appears on the Medicaid Hospice Election form.

g. Enter the period that the hospice member is entering in the LOC field (52H, or 53H). Enter the reason for starting a hospice period in the start reason field.

h. Enter the approved start date for the period being set up in the start date field (CCYYMMDD). Never enter a date before 7/1/97.

i. Enter the reason for stopping a hospice period in the stop reason field (51H, 52H, 53H, 54H, and 55H).

j. Enter the appropriate stop date based on the segment being set up. The stop dates should be 90 or 60 calendar days from the start date, depending on the period (CCYYMMDD). For members dually eligible, enter an open-ended date segment of 2299/12/31.

k. Send decision letter to the provider and the member indicating the hospice period was approved and entered.

l. File the request and retain for three years.

4. The following is the process for member re-enrollment in the hospice program.

a. Review the system update to ensure that all forms are present for re-enrollment. These are the Medicaid Physician Certification form, the Medicaid Hospice Election form, and the Medicaid Hospice Plan of Care Form. If all forms are not included, suspend the request.

b. Verify that the request is a re-enrollment by looking at the stop reason of the previous segment on the LOC window. The stop reasons that denote re-enrollment are 51H and 52H.

c. Refer to the new enrollment directions to complete the re-enrollment, beginning in **Section L-1-a.**

5. The following is the process for member revocation or discharge.

   a. The support specialist will date stamp the system update form and place the mailed or faxed Medicaid Hospice Revocation and Medicaid Hospice Discharge forms in a hospice assignment group folder.

   b. The system updates will be forwarded to the hospice analyst.

   c. The hospice analyst will retrieve the existing prior authorization and review the documentation to avoid duplication of revocation or discharge.

   d. Verify that the form received is complete and signed by the member, or their representative, and a witness.

   e. Proceed to the LOC window to revoke or discharge the hospice member.

   f. Close the LOC segment for the member using the appropriate start and stop reason codes (revocation 51H or discharge 52H-54H).

   g. Send a decision letter to the provider and the member.

6. The following is the process for member change of provider.

   a. The support specialist will date stamp and place the system update with the Hospice Provider Change Request between Indiana Hospice Providers form in the hospice assignment group folder.

   b. The system updates will be forwarded to the hospice analyst.

   c. Retrieve the prior authorization` and review the documentation to avoid duplication.

   d. Verify that the form received is complete and signed by the member and a witness.

   e. Proceed to the LOC window to change the hospice member's responsible provider. If the LOC segment does not match, alert the LOC department at EDS, 317-488-5000, and the OMPP Long Term Care Reimbursement Unit, 317-233-1956.

If a new enrollment request is received that does not include a Hospice Provider Change Request between Indiana Hospice Providers form and there is a current benefit period approved with another provider, the hospice analyst will suspend the request and ask the provider to complete the form and resubmit the request. The hospice analyst will end the existing benefit period one day prior to the change in status date. The new LOC segment will reflect the new provider number and begin on the date of the status change. The previous LOC segment and the new LOC segment days authorized will total one benefit period only.

f. Close the LOC segment for the member using the appropriate stop reason code (transfer to another provider 53H).

g. Open the LOC segment for the member using the appropriate start reason code (transfer to another provider 53H).

h. Send the provider a decision letter verifying receipt of system update and that the change has been made in the system.

7. The following is the process for member change in status.

a. The support specialist will date stamp and place the system update with the Change in Status form in the hospice assignment group folder.

b. The hospice folder will be forwarded to the hospice analyst.

c. Retrieve the existing prior authorization and review the documentation to avoid duplication.

d. File the documentation. No change to the member LOC window is necessary.

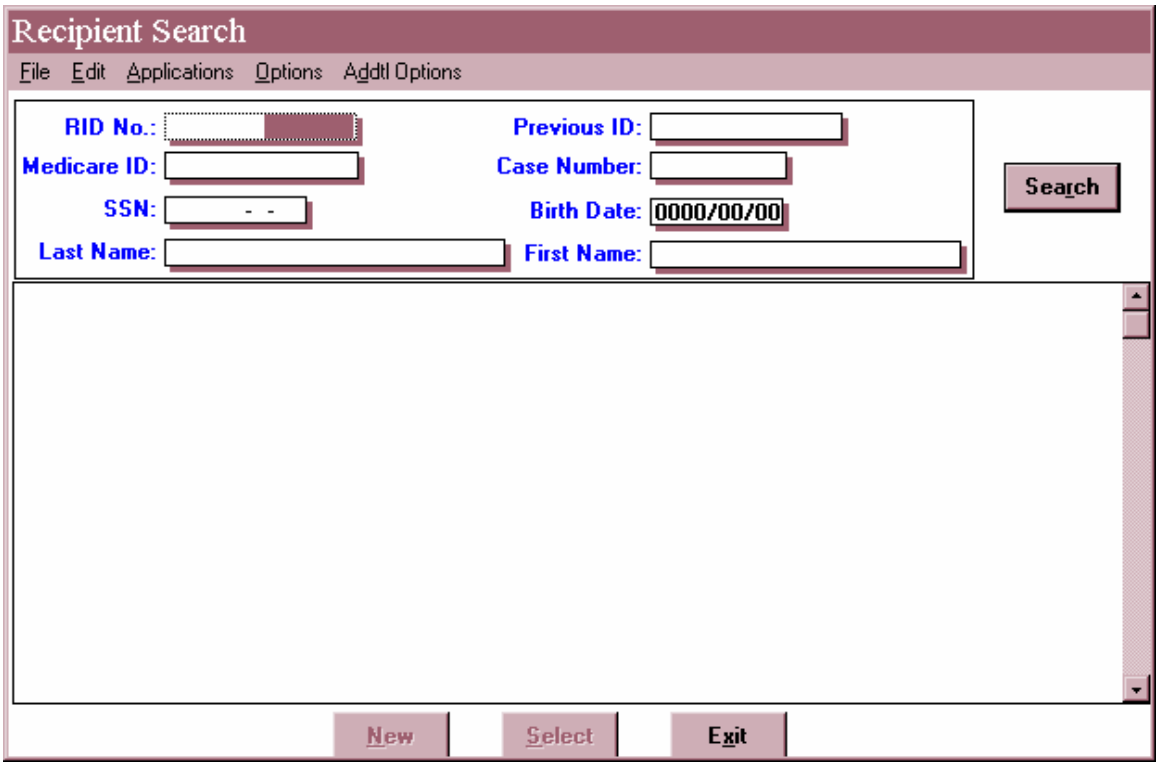
e. Verify that the nursing home LOC segment matches the request. If the LOC segment does not match, alert the LOC department at EDS, 317-488-5000, and the OMPP Long Term Care Reimbursement Unit, 317-233-1956.

f. Send the provider and member a decision letter informing of the change to request.

Refer to **Figures III-18** through **III-23** for a detailed illustration of entry of hospice review into the Indiana*AIM* system.

FIGURE III-18

WINDOW: RECIPIENT SEARCH



To access the Level of Care Window for entering hospice information:

1. Click on Applications on any Indiana*AIM* window.

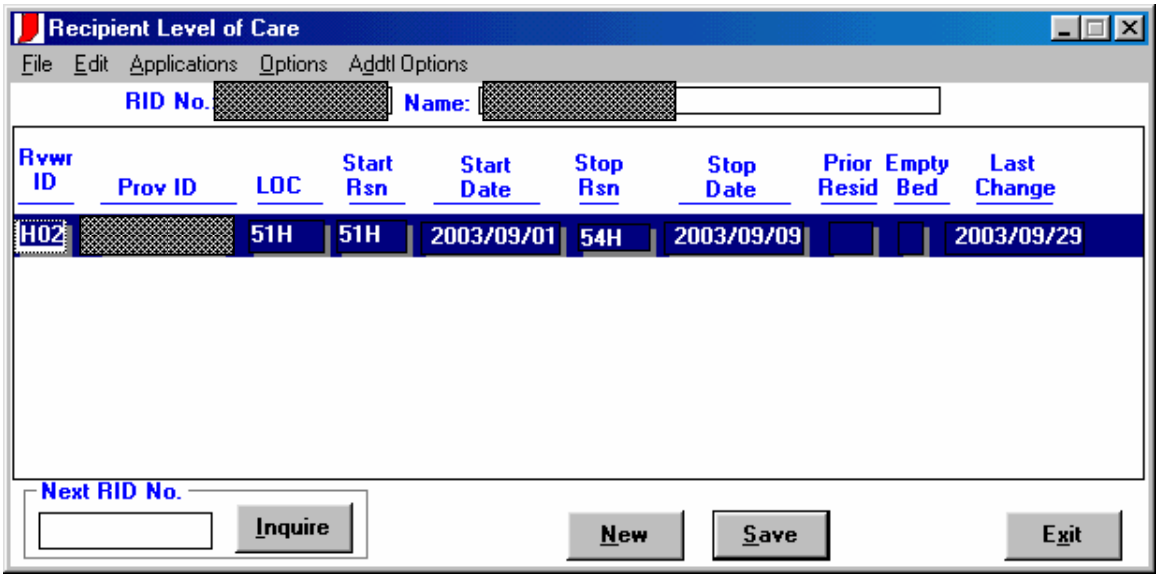
2. Click on recipient window.

3. Enter the Recipient Identification Number (RID).

4. Click on Search.

FIGURE III-19

WINDOW: LEVEL OF CARE WINDOW



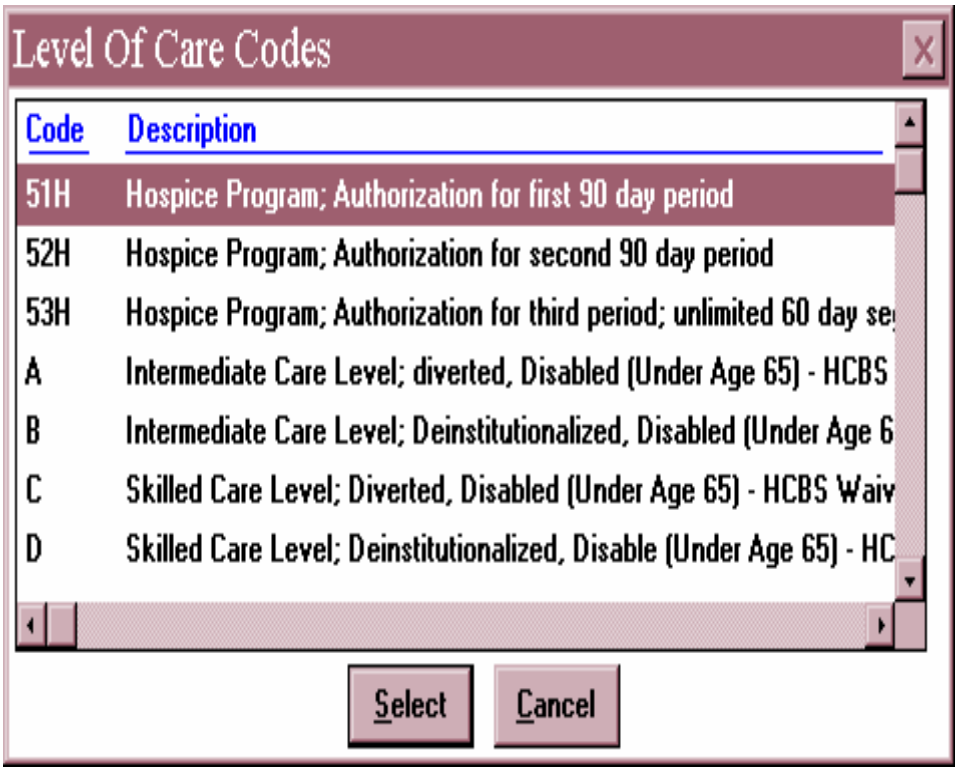
For entering Hospice information:

1. On recipient search screen, click on Options.

2. Then, click on LOC

FIGURE III-20

WINDOW: LEVEL OF CARE OPTIONS

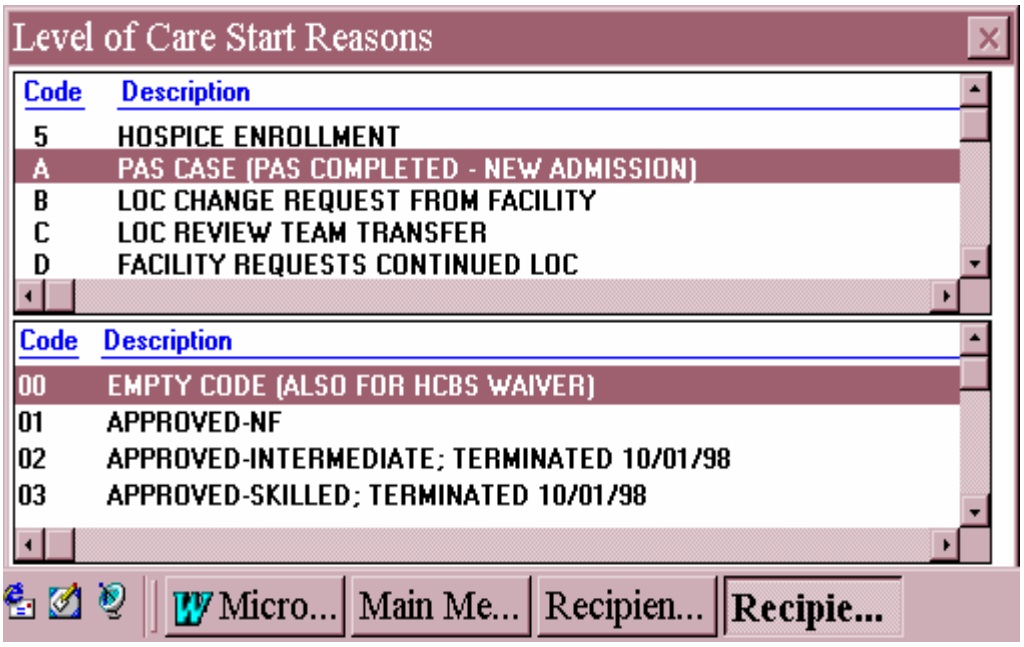


1. By double clicking on the box beneath LOC, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the window will reveal all the possible options.

FIGURE III-21

WINDOW: LEVEL OF CARE START REASONS

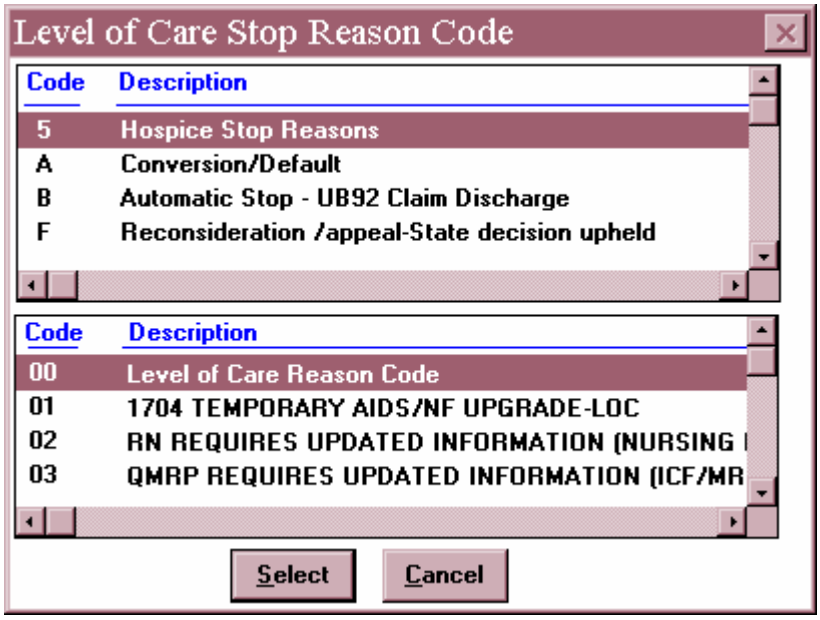


1. By double clicking on the box beneath Start Rsn, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the windows, all the possible options will be visible.

FIGURE III-22

WINDOW: LEVEL OF CARE STOP REASONS

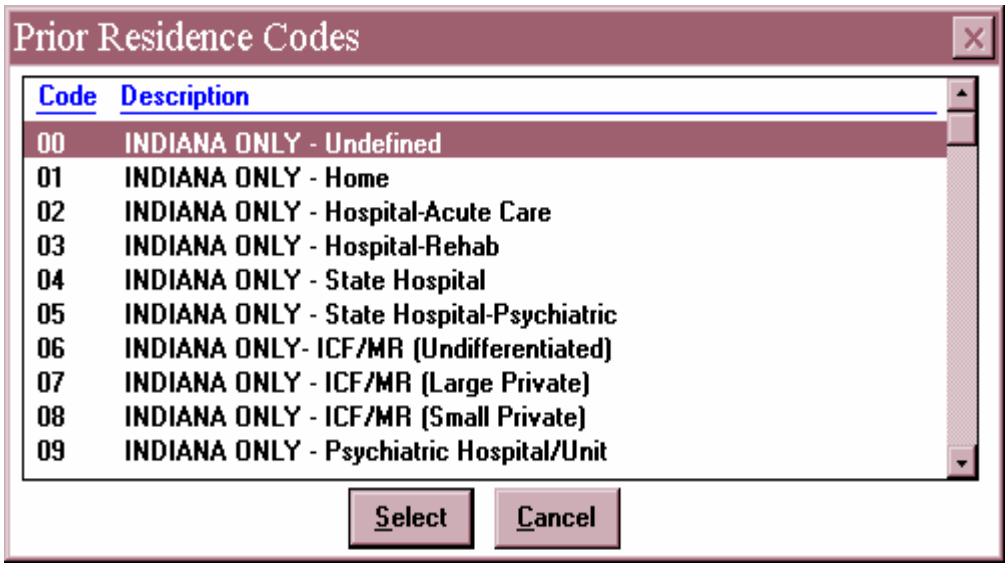


1. By double clicking on the box beneath Stop Rsn, the box printed above will show.

2. Clicking on the scroll bars, either at the bottom or at the right of the windows, all the possible options will be visible.

FIGURE III-23

WINDOW: LEVEL OF CARE PRIOR RESIDENCE



1. By double clicking on the box beneath Prior Resid, the box printed above will show.

2. Clicking on the scroll bar at the right of the window will reveal all the possible options.

M. Waiver Services and Medicaid Prior Authorization

Six Medicaid Home and Community-Based Services (HCBS) waiver programs are part of the Indiana Health Coverage Programs and are administered by the Medicaid Waiver Unit of the Division of Disability, Aging, and Rehabilitative Services (DDARS). These waiver programs offer assistance to eligible members, allowing them to remain in non-institutional environments. To be eligible, members must be at imminent risk of institutionalization in the absence of the waiver services. Once an individual begins participating in the Medicaid HCBS waiver program, he or she is no longer eligible to participate in managed care programs or to receive services under any other waiver.

As a part of the Indiana Health Coverage Programs, Home and Community-Based Services (HCBS) includes six subprograms:

- Aged and Disabled Waiver,
- Autism Waiver,
- ICF/MR (Intermediate Care Facility/Mentally Retarded) Waiver,
- Medically Fragile Children's Waiver,
- Traumatic Brain Injury Waiver,
- Supportive Services Waiver.

The purpose of the waiver program is to provide the services necessary to allow the eligible member to avoid institutionalization. However, the cost of the waiver services is not to exceed the cost to IHCP of institutionalization. Services requested for members on waivers will continue to be evaluated for medical necessity and reasonableness, however service will not be denied based on cost.

Services and supplies that require prior authorization, and which are requested for waiver members, are reviewed for medical necessity and reasonableness, as are all requests for prior authorization. (Refer to the **Prior Authorization Procedures**). The decision whether to allow or deny the request should not be influenced or changed by the fact that waivers may be involved. If a denial should occur, the member need not appeal the denial.

After the denial has been received, the request can be taken to the appropriate waiver case manager for approval through the waiver program. The PA should include the name of the waiver case manager, so the correct person can be notified. A waiver case manager may be with one of the following:

- one of the 16 Area Agencies on Aging;
- one of the eight Bureau of Developmental Disabilities Services (BDDS) Field Offices;
- an independent case management agency; or
- an independent case manager.

Some waiver services are also covered under the IHCP program, and require an IHCP PA denial before the waiver program will pay for them. They are:

- speech/language therapy;
- occupational therapy;
- physical therapy;
- all adaptive aids/devices;
- all items considered assistive technology; and
- durable medical equipment.

Other specified services necessitate an approval by the waiver case manager and the Medicaid Waiver Unit before a client can receive the services. These services are requested by using the Request for Approval to Authorize Services form; a form utilized only by the waiver programs.

The services and items that require this approval are:

- institutional respite care;
- assistive technology (after receiving a IHCP PA denial);
- home modifications;
- environmental modifications;
- adaptive aids and devices (after receiving a IHCP PA denial);
- and personal emergency response systems.

The HCE PA department has no role in the authorization of these services.

It must be noted that computer system errors may necessitate that waiver services, approved by the waiver case manager, be entered into the system as "approved" (indicating the services as "approved by waiver" in the internal text screen) for reimbursement purposes only. For clarification, the PA Supervisor should be consulted.

N. Review of Out-of-State Services

Prior Authorization for out-of-state services should be performed following the normal review process, subject to the following. Refer to 405 IAC 5-5.

Medicaid reimbursement is available for the following services provided outside Indiana:

- acute general hospital care;
- physician services;
- dental services;
- pharmacy services;
- transportation services;
- therapy services;
- podiatry services;
- chiropractic services;
- durable medical equipment and supplies; and
- hospice services subject to conditions in 405 IAC 5-34-1. Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana, even if the nursing facility is located in an out-of-state designated city listed below unless approved after phone contact with the LOC department at the state.

1. All listed services are subject to the prior authorization requirements of Indiana. The above services require prior authorization <u>except</u> as follows.

    - Emergency services provided out-of-state are exempt from prior authorization; however, continuation of inpatient treatment and hospitalization is subject to the prior authorization requirements of Indiana.

- Members of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.
- Members may obtain services listed above in the following designated out-of-state cities, subject to the prior authorization requirements for in-state services.

Louisville, KY	Sturgis, MI
Cincinnati, OH	Watseka, IL
Harrison, OH	Danville, IL
Hamilton, OH	Owensboro, KY
Oxford, OH	Chicago, IL*

*Members in Chicago, Illinois, may obtain services subject to the following:

- **only** if a member's physician determines the service is medically necessary;
- if transportation to an Indiana facility would cause undue hardship to the member or the member's family;
- if the service is not otherwise available in the immediate area; and
- the member's physician complies with all criteria set forth in the state plan and 42 CFR 456.3.

2. Prior Authorization may be granted for any time period from one day to one year for out-of-state medical services listed above, if the service meets criteria for medical necessity and one of the following criteria is also met.

   a. The requested service is not available in Indiana, e.g., long-term Traumatic Brain Injury placements. (Veterans Administration and Shrine hospitals are exceptions.)

   b. The member has previously received services from the out-of-state provider.

   c. Transportation to an Indiana facility would cause undue hardship on the member or the Indiana Health Coverage Programs.

   d. The out-of-state provider is a regional treatment center or distributor.

e. The out-of-state provider is significantly less expensive than the Indiana providers of the same service(s). For example, large laboratories versus an individual pathologist.

Refer to the specific criteria for each service requested. See **Section III-O,** for specific instructions for Traumatic Brain Injury (TBI) patients being cared for in out-of-state facilities.

Note: Prior Authorization will not be approved for the following services outside of Indiana. These services are not covered outside of Indiana in the cities listed in **Section III-N-1.**

- Nursing facilities or ICFs/MR.
- Any other type of long-term care facility, including facilities directly associated with, or part of, an acute general hospital.

3. Commercial Air Transportation

Requests for scheduled commercial air transportation for approved medically necessary services should be received by mail and forwarded to a prior authorization supervisor who will consult with the prior authorization director and the OMPP if necessary. The prior authorization supervisor, in coordination with a consultant travel agent, will arrange approved air transportation.

a. The provider and member, if necessary, will be contacted to determine the scheduled dates of service, length of stay, flight origination, and destination.

b. Consideration should be given to any special needs or flight arrangements necessary to accommodate a member's medical condition.

c. The most affordable flight will be arranged with the travel agent. The flight cannot be confirmed until payment is received by the travel agent. Any airfare pending must be paid in full by check by the close of the business week.

d. The SUR recoupment specialist will initiate a check request for the full airfare price from EDS to be received in the travel agent office by the end of the business week.

e. The provider and member are contacted to confirm that flight arrangements have been secured. Travel itinerary (and flight coupons if necessary) is mailed to the member.

O. Review of Traumatic Brain Injury Cases

Traumatic Brain Injury (TBI) patients often have special needs that make placement difficult. If in-state placement is not possible, out-of-state placement may be made, provided prior authorization requirements are met. (See the Policy and Procedure for prior authorization of out-of-state services.) This process is different from most other prior authorization functions; the cases are not entered into the Indiana*AIM* system, and no PA number is given.

1. Requests for out-of-state TBI prior authorization will be received in the Prior Authorization department.

2. The case will be entered into an Access Database. Initial data entered will include: member name; RID number; requesting provider name and number; planned facility; and planned admission date.

3. The reviewer will evaluate the request to ensure that all required documentation is present, including:

   - the physician's Indiana IHCP provider number and specialty;
   - the length of time the physician has known and treated the member;
   - the member's RID number;
   - the member's age and other identifying characteristics;
   - the member's present Rancho level (if applicable);
   - the member's current residence;
   - a summary of the member's complete medical history, including any past hospitalizations and rehabilitation services;
   - the initial date of any head injury and any history of previous head injury or cerebral harm;
   - a thorough description of any abnormal behavior, including aggressiveness, sexual inappropriateness, danger to self or others, and a description of how this has been dealt with (using concrete examples);
   - history of any attempts at in-state placements;
   - potential for rehabilitation (and the basis for that estimated potential);
   - any neuropsychiatric evaluation (if performed);

- history of the member's pre-injury behavior and social condition (including history of drug use, abuse, or police arrests);
- any psychiatric history (depression, suicide);
- what out-of-state TBI facility has been contacted and any assessment from them; and
- plans for the member's eventual return to Indiana.
- eligibility is checked through the Indiana*AIM* system. Members in a Risk Based Managed Care Organization (RBMC) must be disenrolled prior to authorization for admission. HCE will contact the Managed Care Organization (MCO) requesting disenrollment. Once confirmation of disenrollment is received, the member can be admitted to the out-of-state TBI program. If the member is discharged from the out-of-state TBI program, HCE is required to contact the appropriate RBMC organization.

4. The rationale for any decisions will be stated clearly and concisely. Criteria currently in use include the following:

   - The member is a Rancho Level V or greater.
   - The member demonstrates a reasonable expectation for improvement with therapy.
   - The member is free of acute mental illness or illicit drug use.
   - The member is medically stable.
   - The member cannot be placed, and adequately cared for, in any in-state facility.

5. The case will be returned to the PA Director, and additional data will be entered into an Access Database. These data will include: decision; rate of reimbursement; date authorization expires; and comments. The table will also contain fields for date update completed, discharge date, and disposition.

6. If there is anything unusual about the case, an inquiry may be made by the PA director to OMPP.

7. If criteria are not met, the admission is denied. A denial letter and appeal rights are mailed to the out-of-state provider and to the member.

8. If approved, a letter is sent to the provider giving a synopsis of the services, date the authorization expires, and amount of per diem approved.

9. The TBI Reviewer will produce a two-part monthly status report. The first part will contain a summary of current residents by facility, a listing of admissions within the month, and a listing of discharges within the prior 90 days. The second part will include a detailed summary of each active or recently discharged patient, including:

    - patient name, RID, date of birth, case manager
    - admission date(s), Rancho score, initial injury summation
    - list of all dates authorized and the negotiated per diem cost for each extension of days
    - current status report/progress update.

10. The report will be distributed to the Director of Prior Authorization, OMPP, and EDS.

11. TBI out-of-state admissions are authorized using the HCPCS code H2013 with the modifier of UI.

P. Prior Authorization and Third-Party Liability

If prior authorization is required for a particular service, and the patient has another insurance coverage that is primary, Medicaid prior authorization must still be obtained in order to receive payment for the balance of charges not paid by the primary insurance. However, prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare, and Medicare allows for the services in whole or in part. Services not covered by Medicare are subject to normal prior authorization requirements. Prior Authorization should be performed utilizing the normal review process.

Q. Referrals to Surveillance and Utilization Review

There may be occasions when HCE staff members become aware of possible cases of fraud or abuse. These cases may be identified in a number of ways, including, but not limited to the following.

- Recognition of "red flags" for fraud and abuse (e.g., PA request forms that appear to have been copied with the same set of requested services on each regardless of age or diagnosis; reports that paid services were not provided; repeated requests for excessive units or dollars; or reports that a member has received a lesser quality item than what was approved).

- Complaints or comments made by customers who have called for other reasons.

- Comments made at meetings of providers or members.

1. The following procedure should be followed.

   a. All staff will be appropriately trained on health care fraud and abuse during their orientation program.

   b. Should a staff member receive a telephoned complaint, the call should be transferred to the "Member Concerns Line," if possible.

   c. Should a staff member identify any suspicious activity, or the caller refuses to be transferred, the staff member should complete the Referrals to Surveillance and Utilization Review form. (Refer to **Figure III-25**.)

d. The staff member should submit the completed form to his or her supervisor.

e. The supervisor will submit the form to his or her department director.

f. The department director will submit the form to the Director of Surveillance and Utilization Review.

g. The SUR Director will give feedback, at periodic intervals, of the results of these referrals to the reporting department director.

h. The department director will give feedback to the reporting employee regarding the disposition of the case. This will provide positive reinforcement and recognition to reporting employees.

FIGURE III-25

REFERRALS TO SURVEILLANCE AND UTILIZATION REVIEW
INDIANA MEDICAID REFERRAL FORM

INDIANA MEDICAID REFERRALS FOR HCE USE ONLY: PROV. COS/CLASS

PROV. TYPE/SPEC _____ REC. AGE/CLASS _____

DATE OF CALL___/___/___ COMPUTER RECORD #:_____

OPERATOR_____

TYPE CODE

[ ] 14 Recommendation
[ ] 15 Provider
[ ] 16 Member
[ ] 17 Other

SERVICE CLASS

[ ] Transportation
[ ] Chiropractors
[ ] Nursing Home
[ ] Physician
[ ] Hospital
[ ] Pharmacy
[ ] Home Health Care
[ ] Dentist
[ ] Psychiatric Services
[ ] Other

COMPLAINT TYPE

[ ] Reform health care system (OMPP)
[ ] Give people incentive to work (OMPP)
[ ] Improve eligibility process (OMPP)
[ ] Misreport income (County)
[ ] Elderly hiding assets/income (County)
[ ] Able to work, but doesn't (County)
[ ] Employed-Insurance available (County)
[ ] Falsified eligibility information (County)
[ ] Uses someone else's card (County)
[ ] Treats members poorly (IMFCU)
[ ] Recruiting patients (IMFCU)
[ ] Doesn't report other health ins. (TPL)
[ ] Excessive/ Unnecessary Services (SUR)
[ ] Charges too much (SUR)
[ ] Charges client for services (SUR)
[ ] Mis/over-utilization of chiropractors (SUR)
[ ] Mis/over-utilization of transportation (SUR)
[ ] Mis/over-utilization of prescriptions (SUR)
[ ] Mis/over-utilization of doctors (SUR)
[ ] Mis/over-utilization of emergency (SUR)
[ ] Charges for services not provided (SUR
[ ] Other

COMMENTS

COMPLAINT AGAINST

NAME_____
ADDRESS_____
CITY_____**STATE**_____**ZIP**_____
MEDICAID #:_____**PROVIDER#**_____

CALLER INFORMATION

NAME_____
ADDRESS_____
CITY_____**STATE**_____**ZIP**_____
PHONE (____)_____**COUNTY**_____

R. Inpatient Burn Prior Authorization

Prior Authorization (PA) requests received for inpatient burn treatment (revenue code 207) will be entered into Indiana*AIM* and processed as approved.

S. Review of Cases Suspended to Location 22

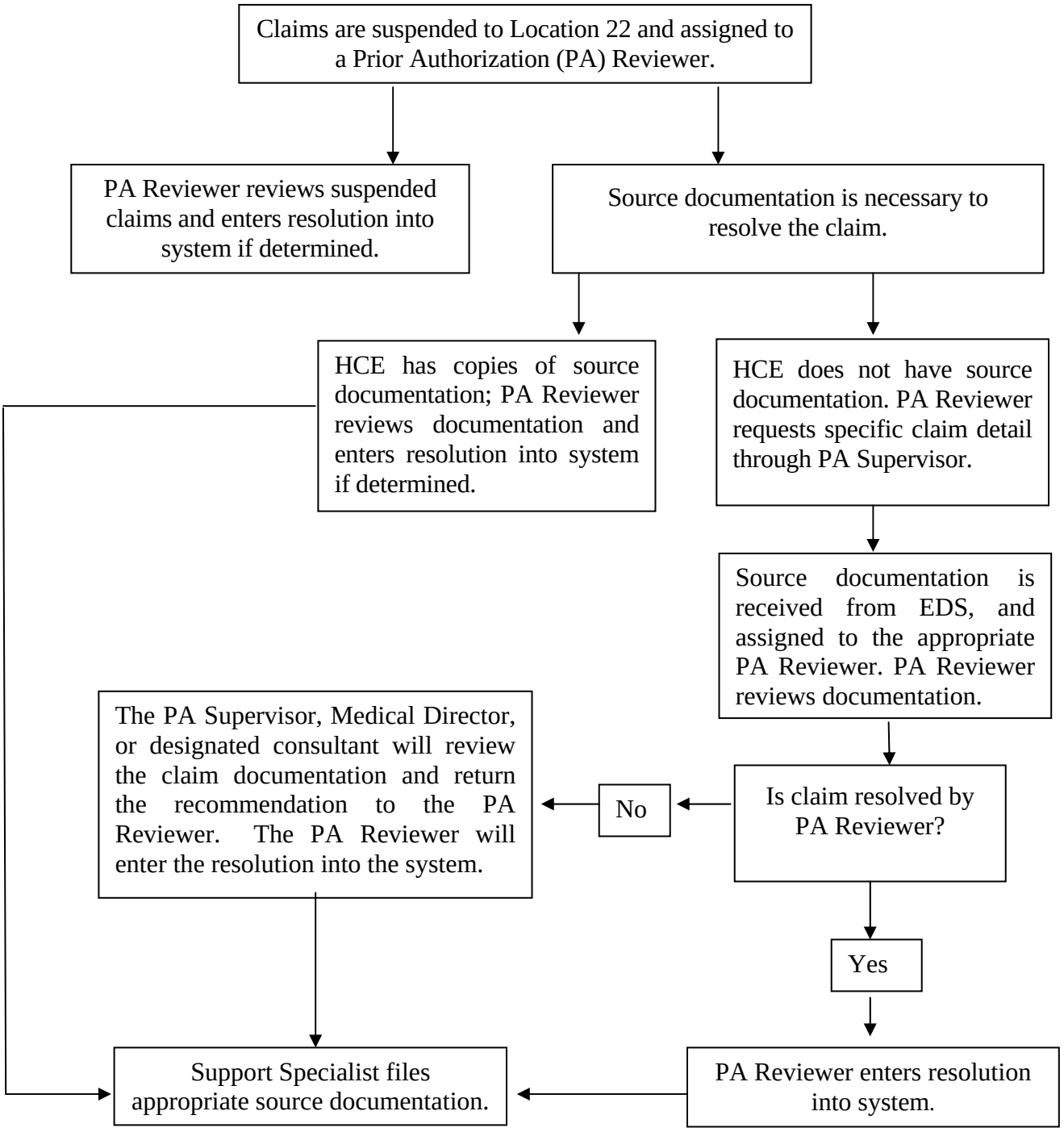
Claims are automatically suspended to "Location 22" when they meet criteria listed in certain audits that signify the need for medical review. Location 22 is the electronic location designated in the Indiana*AIM* system for these suspended claims. The Prior Authorization department will review, research, and resolve these claims within 60 days of receiving the source documentation (claims and attachments.) (Refer to **Table III-14** and the Location 22 Procedure Flowchart.)

TABLE III-14

LOCATION 22 PROCEDURE

No.	DESCRIPTION OF ACTIVITY	RESPONSIBLE PARTY
1.	Claims are suspended to Location 22 within the EDS claims system. On a regular basis, EDS staff will also copy paper claims with attachments and send them to HCE.	EDS
2.	The Prior Authorization (PA) Supervisor will review in Indiana*AIM* the electronic claims pending from the previous day in each PA reviewer's workload. The total will be entered into the Location 22 report as "# Claims Remaining at end of Day" for the appropriate date.	PA Supervisor
3.	The PA Supervisor will review the new claims loaded to the designated workload location, and enter the number of claims received in the Location 22 report as "# Claims Received."	PA Supervisor
4.	The PA Supervisor will reassign claims to the designated PA reviewers based on training, amount of claims remaining from previous day, and other workload requirements.	PA Supervisor
5.	Upon receipt by HCE, each packet of claims will be checked to verify all claims listed on the face sheet are included in the packet. The face sheet will be date stamped when received by HCE. Each claim will be noted as "R" (received) or "NR" (not received). The marked face sheet will be faxed back to the designated contact at EDS and the fax transmission report retained in files.	PA Supervisor or Support Staff
6.	The PA Supervisor will deliver the paper packet of claims to the designated PA reviewer.	PA Reviewer
7.	PA Reviewers will review each claim, either electronic or electronic with paper attachments, and enter the claim resolution, if determined, into the system. The PA Reviewer will notify the PA Supervisor of any unresolved claims each day.	PA Reviewer
8.	After the source documentation (paper claim with attachments) is received and reviewed, if the PA Reviewer is unable to make resolution determination, the PA Reviewer will forward the documentation with a PA Consultant Review form, to the PA Supervisor.	PA Reviewer
9.	The PA Supervisor will contact the Medical Director to arrange physician or consultant review of the documentation and claim form.	PA Supervisor
10.	The Medical Director will coordinate the review of the documentation, and return the completed Medical Necessity form to the PA Reviewer who will complete the claim resolution.	Medical Director
11.	If source documentation has not been received for paper claims with attachments (Region 11) which the PA Reviewer cannot resolve, a written request for specific claim detail information should be submitted to the EDS Point of Contact through the PA Supervisor.	PA Supervisor
12.	The PA Reviewer will report any findings from resolving Location 22 claim suspensions that may require a systems change or policy change. The Medical Policy Director forwards the information to the PA Reviewer, OMPP or EDS as appropriate.	PA Reviewer Medical Director
13.	Source documentation regarding abortion claims will be retained in files specific to Location 22.	Support Specialist
14.	All other paper claims and attachments will be disposed of in accordance with standard policies on disposal of information containing PHI.	PA Reviewer
15.	Original face sheets and fax confirmation sheets verify receipt of paper claims with attachments will be retained in files specific to Location 22, and separate from claims containing PHI.	Support Specialist

LOCATION 22 PROCEDURE FLOWCHART



T. Review of Long Term Acute Care, Hospital Admissions

Prior Authorization (PA) is required for Long Term Acute Care (LTAC) hospital admissions covered by the Indiana Health Coverage Programs (IHCP) and reimbursed under the level of care methodology described in the Indiana Administrative Code (IAC) 405 IAC 1-10.5. LTAC hospitals are designed to provide specialized acute care for patients that require a longer recovery period. These patients usually are in an acute care facility and their medical condition has stabilized, but they continue to require an acute level of care, such as skilled nursing facilities (SNF) or sub-acute care facilities. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Members must meet the admission and continued criteria outlined in IHCP Bulletin 200366, dated October 31, 2003. This service is requested using revenue code 101. All requested days and dates of service will be entered into Indiana*AIM* and processed in the usual manner (see **Section III-A** for the manual process of processing a request into Indiana*AIM).*

U. Psychiatric Residential Treatment Facility Services

The Office of Medicaid Policy and Planning (OMPP) implemented coverage of Psychiatric Residential Treatment Facility (PRTF) services when provided in accordance with the requirements listed in Bulletin 200404 with services retroactive starting January 1, 2004. The Bulletin outlines the provider enrollment requirements, coverage provisions and limitations, reimbursement methodology, billing requirements and prior authorization criteria for PRTF services. All providers must qualify for enrollment eligibility in the Indiana Health Coverage Programs (IHCP) as a PRTF facility and must be licensed under Indiana Administrative Code (IAC) 470 IAC 3-13 as a private, secure, child-caring institution, and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or the Council on Accreditation (COA).

This service is covered for members 21 years old or younger**. Reimbursement is also available for children younger than 22-years-old who began receiving PRTF services before their 21st birthday.**

All services require prior authorization. Members must meet the admission and continued criteria outlined in Bulletin 200404 dated February 27, 2004. This service is requested using HCPCS T2048. All requested days and dates of service will be entered into Indiana*AIM* and processed in the usual manner (see **Section III-A** for the manual process of processing a request into Indiana*AIM).* If a member is in a managed care organization (MCO), a manual letter is sent to the appropriate MCO notifying them of the member's admission.

EXHIBIT III-1

TELEPHONE SCRIPTS

A. Scripts for Telephone System Recordings

1. Daytime Recording

Thank you for calling the Indiana Medicaid Prior Authorization Department in Indianapolis, Indiana. Office hours are 7:30 am to 6 pm, Monday through Friday. Your call may be monitored for quality improvement purposes. As of February 16th, all requests for drugs and DUR edits are handled by the ACS Clinical Call Center at 866-879-0106. Authorization of Indiana Medicaid services is based upon medical necessity and documentation must support this. Prior authorization does not guarantee payment. Please listen carefully as the call options have changed. For mental health service, please press 1. For home health or hospice, press 2. For DME or other medical/surgical services, press 3. For hearings and appeals, please press 8. For all other services, press 4. To access our company website, log on to www.hce.org If you are calling from a rotary phone or need further assistance, please remain on the line. Thank you.

2. Queue Recording

All prior authorization reviewers are assisting other callers. Your call is important to us. Your call will be answered in the order that it was received. Health Care Excel authorizes services based upon medical necessity. Medical record documentation should support this medical necessity. Please hold for the first available reviewer.

3. After-hours Recording

You have reached the Indiana Medicaid Prior Authorization Department in Indianapolis, Indiana. Our office is now closed. Office hours are 7:30 am to 6 pm, Monday through Friday. Emergency services should not be delayed due to lack of prior authorization. Prior authorization is based upon medical necessity, which can be requested within 48 hours of the receipt of emergency service. Please call again during normal business hours. To access our company website, log on to www.hce.org. Thank you.

B. Script for a Typical Prior Authorization Request Telephone Call

Facility telephones the prior authorization toll-free number and makes a selection.

HCE Reviewer:	Health Care Excel Prior Authorization, this is "HCE Reviewer." How may I help you?
Caller:	Yes, I am calling from a psychiatric facility, and I need to authorize a patient's stay.
HCE Reviewer:	I would be happy to help you with that. Can you tell me your facility's provider number? *If the requesting provider is not enrolled, the license number and address must be obtained and entered into* Indiana*AIM.*
Caller:	(gives provider number or license number and address, as appropriate)
HCE Reviewer:	Is this a new admission or a continuing stay request?
Caller:	This is a new admission.
HCE Reviewer	The Recipient Identification Number is…?.
Caller:	(provides the necessary information)
HCE Reviewer:	The patient's name is ..?
Caller:	(caller must state name)
HCE Reviewer:	Can you tell me the type of service you are requesting, and start date and/or admit date (if not already known)? Can you tell me the diagnosis code?
Caller:	(If yes, continue with review. If no, the caller must determine the diagnosis code.)
HCE Reviewer:	And what are the Service Code (HCPCS, ICD9 or NDC) and number of days/units you are requesting?
Caller:	Gives code, and requests ten days.
HCE Reviewer:	And your name is…? (If they have not stated their name at the beginning of the call. If they have, the reviewer should have written down the name. This information is entered into the internal text.)
Caller:	My name is "caller".
HCE Reviewer:	And your telephone number is…? (This is also entered into the internal text.)
Caller:	(Gives the information.)
HCE Reviewer:	(If home health, DME, etc, would ask, "Does the member live at home or in another location, and if another location, where?")
Caller:	(Gives the information.)
HCE Reviewer:	Thank you. Can you tell me the patient's signs and symptoms, plan of care and initial discharge plan?

Script for a Typical Prior Authorization Request Telephone Call (continued)

Caller:	Yes, gives information.
HCE Reviewer:	Based upon the information you have given me, I can approve five (5) days in your unit (this is a modification). That would make your authorization valid through (give date) as the last covered day. You must call back no later than the following business day if the patient remains hospitalized at that time. This is pending verification and receipt of the Certification of Need within the 14-day required timeframe. Do you have any questions? (If the case did not meet criteria, the caller would have been informed of this, and told when to expect a decision to be rendered.)
Caller:	No, thank you.
HCE Reviewer:	(Caller), the Prior Authorization number for this stay is 9999999999. You know that the stay will be pended until we receive the 1261A Certification of Need. Is there anything else I can assist you with?
Caller:	No, thank you.

EXHIBIT III-2

MEDICAL RATIONALE

The consultant will read the reviewer's case summary information and review all of the available documentation to determine whether the service is medically justified and allowable under Indiana statutes and policies.

A good medical rationale is necessary and central to the review process. As the consultant writes his or her case determination, he or she must adhere to the following principles.

1. Compose your rationale as if you were addressing your comments or questions to the responsible provider or practitioner(s). Please keep in mind that your answer may be used in letters to the provider or practitioner(s) who provide services to the patient.

2. Be specific and coherent in your answers. Avoid "generic" answers – answers that are so broad and nonspecific that they could apply to numerous patients in various cases. Avoid such "generic" answers by writing rationale which includes relevant, specific items from any of the following which are available for your review:

    a. history and physical exam;
    b. progress notes;
    c. nursing notes;
    d. graphic charts;
    e. laboratory reports;
    f. x-ray reports;
    g. other diagnostic tests and reports;
    h. consultations, operative notes, and miscellaneous reports;
    i. discharge summary; and
    j. additional information from letters, telephone and personal interviews from providers that may be available for review.

3. Cite accepted, commonly recognized standards of care, not personal preferences.

EXHIBIT III-3

CONSULTANTS
AVOIDING COMMON REVIEW ERRORS

As you review the medical record and document the rationale for your decision, be careful to avoid common review errors. You can improve the reliability of review by adhering to the following principles.

1. **Write legibly.** This simple procedure avoids errors that can occur if staff members must try to decipher illegible writing.

2. **Review all of the documentation presented.** Perhaps the most egregious errors are those in which the reviewers simply fail to read documentation that is present in the record.

3. **Confirm all statements and information given to you by the non-physician reviewer with your own independent review of the documentation.** The reviewer may not have noted each pertinent item of the patient's history, physical exam, progress notes, lab results, physician orders, consultation notes, etc. When the consultant assumes the reviewer's statements are always correct, the consultant duplicates errors that may have been made in earlier levels of review.

4. **Avoid excessive reliance on the results of diagnostic studies rather than on clinical documentation.** When there is a question as to whether a service should have been ordered or performed, read the entire document carefully to ascertain whether the provider made an appropriate clinical evaluation and assessment without over-utilization of such services.

5. **Allow acceptable, alternative methods of patient evaluation and care.** As long as the provider under review displays adherence to standards of care and sound medical judgment, there are often multiple acceptable approaches to medical problems. Do not judge care unacceptable merely because it does not follow your own personal choice.

6. **When reviewing services retrospectively, avoid excessive use of the "retro-spectroscope."** Review the documentation to see if sound medical decisions were made with appropriate evaluation and care, based upon the information at hand at the time the services were rendered–not upon information which later became available.